

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-025534

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 248 STATE FILE NUMBER

VS 300  
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |  |  |                                  |
|---|--|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St Francois</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Madison</u>               |                                  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Farmincton - RURAL</u>  |  | c. CITY OR TOWN <u>Fredericktown</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                   |                                  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Thomas Dell Memorial Home</u>   |  | d. STREET ADDRESS <u>R.R. 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                       |                                  |
| 3. NAME OF DECEASED<br>(Type or print) First <u>John</u> Middle <u>Brewen</u> Last <u>Brewen</u>  |  | 4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1963</u>  |                                  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/6/1895</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   |                                  |
| 11a. FATHER'S NAME <u>Joseph Brady Brewen</u>   |  | 11b. MOTHER'S MAIDEN NAME <u>Julia Mary Rion</u>   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW 1</u>  |  | 17. INFORMANT <u>William Brewen, Fredericktown, Mo. Rt. 3</u> Address <u>Mo. Rt. 3</u>   |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PARKINSONS DISEASE</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs +</u>  |                                  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |                                  |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____   |  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____  |                                  |
| 21. I attended the deceased from <u>Aug 1960</u> to <u>6-14-63</u> and last saw him alive on <u>6-10-63</u><br>Death occurred at <u>11 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |  |  |                                  |
| 22a. SIGNATURE (Degree or title) <u>C. E. Carleton, M.D.</u>  |  | 22b. ADDRESS <u>Farmincton, Mo</u>   |                                  |
| 22c. DATE SIGNED <u>6-17-63</u>   |  |  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE <u>6/17/63</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>IOOF Cemetery</u>  |                                  |
| 23d. LOCATION (City, town, or county) <u>Knob Lick, Missouri</u>  |  | (State) _____  |                                  |
| 24. FUNERAL DIRECTOR <u>Miller Funeral Home, Farmincton, Mo.</u>  |  | 25. DATE RECD. BY LOCAL REG. <u>June 17, 1963</u>  |                                  |
| 26. REGISTRAR'S SIGNATURE <u>Cather Rudloff</u>   |  |  |                                  |

Dr. Carleton  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

1 0940  
2 0620  
3  
4 0  
5 0  
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9 350X  
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12 86-0  
13 1-0

486590-839

JUN 27 1963

JAN 24 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Paul K. Royal*

Licensed Embalmer No. 4120

P. O. Address

*Farmington, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.